Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Kerendia - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the member have chronic kidney disease associated with type 2 diabetes (CKD with T2D) (documentation attached).?

☐ Yes ☐ No

Q2. Is Kerendia being prescribed by or in consultation with nephrologist, cardiologist, or endocrinologist?

☐ Yes ☐ No

Q3. Have all potential contraindications (concomitant treatment with strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin), adrenal insufficiency, GFR less than 25 mL/min) been excluded?

☐ Yes ☐ No

Q4. Will the member continue therapy with an ACE or ARB at maximally tolerated doses for diabetic nephropathy, or is there an intolerance or contraindication to these therapies?

☐ Yes ☐ No

Q5. Has the patient had a documented inadequate response, intolerance or contraindication to one sodium-glucose co-transporter 2 (SGLT2) inhibitor used for chronic kidney disease (e.g., Farxiga)?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Requested Duration: ☐ 12 Months	☐ Other:
Q7. Additional Information:	

Prescriber Signature

Date